SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
Company Tracking Number:	*134803AR*		
TOI:	*L06I Individual Life - Variable*	*Sub-TOI:*	*L06I.002 Single Life - Flexible Premium*
Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Filing at a Glance

Company: RiverSource Life Insurance Company

Product Name: Life Insurance	SERFF Tr Num: AEMN-125688858	State: ArkansasLH
TOI: L06I Individual Life - Variable	SERFF Status: Closed	State Tr Num: 39689
Sub-TOI: L06I.002 Single Life - Flexible Premium	Co Tr Num: 134803AR	State Status: Approved-Closed
Filing Type: Form	Co Status: Submitted	Reviewer(s): Linda Bird
	Authors: Debbie Berg, Bonnie Foley, Susan Schmidt	Disposition Date: 07/24/2008
	Date Submitted: 07/21/2008	Disposition Status: Approved
Implementation Date Requested: 10/01/2008		Implementation Date:

State Filing Description:

General Information

Project Name: Life/DI 2008 Application	Status of Filing in Domicile: Pending
Project Number: 134803	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Submitted in domicile state of Minnesota on 6/13/08.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/24/2008	
State Status Changed: 07/24/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: Individual Life and Disability Income Insurance Application

Form 134803

(Replaces Application Form 134031A, Approved 10/22/2003, as File No. .)

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
Company Tracking Number:	*134803AR*		
TOI:	*L06I Individual Life - Variable*	*Sub-TOI:*	*L06I.002 Single Life - Flexible Premium*
Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Enclosed is the above-referenced life and DI application that we are submitting for review and approval by your Department. The revised application form replaces a currently used form as stated above. The application will be used to apply for previously approved life and/or disability income insurance policies, and we have attached a listing of those policies to which the application will be attached. We plan to implement use of this application in the 4th quarter of 2008. This application form was filed for approval in our domicile state of Minnesota on July 11, 2008.

This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards.

Changes to the application form include:
Updated the Life Insurance Plan and Riders section to reflect current products.
Addition of a section called, "Agreement to Sell, Transfer or Assign Life Insurance"
Addition of a CD ROM Prospectus acknowledgment.
Overall format and layout changes throughout.
Text revision intended to clarify questions or instructions.

Material that may change is indicated by brackets on the submitted specimens. The attached Statement of Variability describes the bracketed application items.
To the best of our knowledge, these forms comply with the laws and regulations of the State of Arkansas. Certifications as required by your state are enclosed.
Thank you for your consideration of this filing. Please feel free to call or send me an e-mail if there is any assistance I can provide to facilitate your review.

Previously approved policy forms to which the application will be issued:

Description	Form Number Status Approval Date State/SERFF File #
Life Insurance Policies	
Variable Universal Life (VUL)	30061-AR approved 06/16/1998
Foundations universal life (FUL)	30080C approved 10/08/2002
Succession Select Survivorship Life	30090C approved 02/20/2001
Term Insurance - 10 Year	30480A-AR approved 09/02/2003
Term Insurance - 15 & 20 Year	30470A-AR approved 09/02/2003

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
Company Tracking Number:	*134803AR*		
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Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Disability Income Insurance

Disability Income Insurance 30200G Approved 06/25/2007 36199

Disability Income Insurance 30203G Approved 06/26/2007 36204

Disability Income Insurance 30205G Approved 06/26/2007 36205

Disability Income Insurance 30207G Approved 06/26/2007 36203

Disability Income Insurance 30208G Approved 06/26/2007 36201

Company and Contact

Filing Contact Information

Susan Schmidt, Contract Analyst	Susan.2.Schmidt@ampf.com
9507 Ameriprise Financial Center	(612) 671-1734 [Phone]
Minneapolis, MN 55474	(612) 671-3866[FAX]

Filing Company Information

RiverSource Life Insurance Company	CoCode: 65005	State of Domicile: Minnesota
9550 Ameriprise Financial Center	Group Code: 4	Company Type: Life
H22/9550		
Minneapolis, MN 55474	Group Name:	State ID Number:
(612) 671-2465 ext. [Phone]	FEIN Number: 41-0823832	

Filing Fees

Fee Required?	Yes
Fee Amount:	$75.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
RiverSource Life Insurance Company	$75.00	07/21/2008	21513210

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
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TOI:	*L06I Individual Life - Variable*	*Sub-TOI:*	*L06I.002 Single Life - Flexible Premium*
Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/24/2008	07/24/2008

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
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Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Disposition

Disposition Date: 07/24/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
Company Tracking Number:	*134803AR*		
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Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Form	Life and Disability Income Insurance Application		Yes

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
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Form Schedule

Lead Form Number: 134803

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	134803	Application/ Enrollment Form	Life and Disability Income Insurance Application	Initial		40	134803 LIFE-DI Application FINAL (7-10-08) Brkt.pdf

1. RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

1a.

Life and Disability Income Insurance Application

Staple payment here

☐ No money paid with this application

RiverSource Insurance

Section A — Insured and Owner Information

Insured's Phone Number Day: Evening:

2. • An approved Client Profile Form 200152 for each client must be on file prior to or submitted with this application. For address changes, submit Form 518.

3. • An Account Level Suitability Form 402084 must be submitted with each application.

1. Insured: Is Insured the Owner? ☐ Yes ☐ No Citizenship: ☐ U.S. ☐ Other If Other, Insured is:

Insured's Name (First, Middle Initial and Last Name) ☐ Male ☐ Female ☐ Resident Alien ☐ with Green Card ☐ Nonresident Alien

Birthdate (MM/DD/YYYY) State of Birth or Country of Birth U.S. Social Security Number

Occupation Employer Name

Amount Paid With Application $. Driver's License (DL) Number DL State of Issuance

Individual Income $ Net Worth $ Household Income $

2. Second Insured ☐ ? Citizenship: ☐ U.S. ☐ Other

Is Second Insured the Owner? ☐ Yes ☐ No If Other, Second Insured is: ☐ Resident Alien ☐ with Green Card ☐ Nonresident Alien

Second Insured's Name (First, Middle Initial and Last Name) ☐ Male ☐ Female

Birthdate (MM/DD/YYYY) State of Birth or Country of Birth U.S. Social Security Number

Occupation Employer Name

Individual Income $ Net Worth $ Driver's License (DL) Number DL State of Issuance

3. Business Insurance (Complete if insurance is for business purposes)

Type of Business: ☐ Sole Proprietorship ☐ S Corporation ☐ Partnership ☐ C Corporation ☐ LLC

Type of Business Insurance: ☐ Buy/Sell ☐ Business Debt Protection ☐ Split Dollar ☐ Key Person ☐ Executive Bonus/GEBA ☐ Deferred Compensation (nongovernmental) ☐ Other

4. Owner (Complete if Owner is different from Insured/Second Insured) Citizenship: ☐ U.S. ☐ Other If Other, Owner is:

Owner's Name (First, Middle Initial and Last Name) ☐ Male ☐ Female ☐ Resident Alien ☐ with Green Card ☐ Nonresident Alien

☐ Individual ☐ Trust ☐ Business ☐ Other Relationship to Insured

Birthdate (MM/DD/YYYY) TIN or U.S. Social Security Number

5. Trust — Name of Trust Date of Trust (MM/DD/YYYY)

☐ Revocable – Grantor's TIN ☐ Irrevocable – Trust's TIN

Name of Trustee

Address of Trustee

6. Successor Owner: Does the Owner wish to designate a Successor Owner? ☐ Yes ☐ No

If Yes, Successor Owner's Name

Relationship to Owner

Section B — Life Insurance Plan Information

1. Life Insurance Plan

Permanent Insurance Insured Amount $ _____ Purpose of Insurance _____

5.

Universal Life
- ☐ Variable Universal Life (VUL)*
- ☐ Foundations universal life (FUL)*
- ☐ Foundations Protector universal life (FP)

Survivorship Life
- ☐ Succession Select (Variable)*
- ☐ Succession Protector

For variable products, complete item 4 below AND investment option form 33034 OR Portfolio Navigator enrollment form 402048. 3.

*Must select Option 1 or 2 for these plans: ☐ Death Benefit Option 1 ☐ Death Benefit Option 2

Tem Insurance Insured Amount $ _____ ☐ 20-Year ☐ 15-Year ☐ 10-Year

Other _____

2. Life Insurance Riders

6.

- ☐ Accelerated Benefit Rider for Terminal Illness (VUL, FP, FUL)
- ☐ Waiver of Monthly Deduction (VUL, FUL)
- ☐ Waiver of Specified Premium (VUL, FP, FUL) – Monthly Specified Premium $ _____
- ☐ Waiver of Premium (Term)
- ☐ Automatic Increase Benefit Rider: ☐ 2% ☐ 3% ☐ 4% ☐ 5% ☐ 6% ☐ 7% ☐ 8% (VUL, FUL)
- ☐ Accidental Death Benefit of $ _____ (VUL, FUL, Term)
- ☐ Four Year Term of $ _____ (Survivorship Life)
- ☐ Policy Split Option (Survivorship Life)
- ☐ Children's Insurance (CIR) _____ Units (VUL, FUL, Term) Provide Details for CIR in Section I.
- ☐ Other _____

3. Life Insurance Premiums

Annual Scheduled (UL/VUL/Survivorship) Premium
$ _____ . _____

Lump-sum Amount to Be Paid on Delivery of Policy
$ _____ . _____

3.

a. Bank Authorization (BA): ☐ Monthly ☐ Quarterly
☐ New BA Authorization (Complete Form 200517) ☐ Add to Existing BA with Account Number _____

b. Direct Bill: ☐ Quarterly ☐ Semiannual ☐ Annual

c. Card Billing (Term Only): ☐ American Express ☐ Master Card ☐ VISA
Frequency (not available for initial payment) ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually
Card Number _____ Expires _____

d. No Billing ☐ (Not applicable for Term)

e. Other: _____

3.

4. Variable Universal Life and Survivorship Variable Life Information - Check each of the following below to indicate your acknowledgement:
(Also complete investment option allocation form 33034 or Portfolio Navigator enrollment form 402048)

- ☐ **Adequate information.** You have received the current prospectuses for the policy applied for and any funds involved.
- ☐ **Purpose.** You agree that this variable type of insurance is in accord with your insurance and financial objectives.
- ☐ **Variable values.** You understand that the amount of Death Benefit and Policy Value can both increase and decrease; however, the Death Benefit will never be less than any Guaranteed Minimum Death Benefit.
- ☐ **Fees and charges.** The fees and charges have been explained to you and are also explained in detail in the policy.

Consent for Delivery of Initial Prospectuses on CD-ROM

7.

☐ Yes - By checking this box, I acknowledge that I have chosen to receive and have received the initial product and fund prospectuses on computer readable compact disk ("CD"), and that:

- I understand that I have the right to receive the prospectuses in paper format, which has been offered to me.
- I have access to and understand how to use the hardware and software that are necessary to view the prospectuses (see CD label for operating requirements).
- I understand that, in order to retain paper copies of the prospectuses, I must either:
  A. print the prospectuses found on the CD, incurring any printing costs myself; or
  B. request the prospectuses in paper form free of charge by calling Customer Service toll-free at (800) 862-7919.

1.

- I understand that all future prospectus updates and supplements will be provided to me in paper form unless I sign up for online document delivery on the My Financial Accounts website at Ameriprise.com.
- I understand that if I enroll in the Portfolio Navigator Asset Allocation Program and I have checked the box above, I am also acknowledging that I have chosen to receive the initial investment Adviser Disclosure Document and the Investment Advisory Agreement ("Advisory Documents") together with the initial product and fund prospectuses on CD, and that I have all the same rights and make all the same acknowledgments as reflected above with respect to the Advisory Documents.

Section B — Life Insurance Plan Information

5a. Life Insurance Beneficiary (for Survivorship Life, complete 5b. below)

Option A. Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the Insured and they will receive equal shares of the proceeds.

Option B. Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the Insured has died before the Insured, the share which the child would have received if he/she survived the Insured will be paid to his/her living lawful children in equal shares.

Option C. Other designation. (If you select Option C, show the percentage each beneficiary will receive.)

☐ Option A ☐ Option B ☐ Option C

For Option A or B: Insured's Spouse Full Name

For Option C: Other Designation

Relationship to Insured

5b. Survivorship Life Beneficiary Designation

Relationship to Insured

Section C — Existing Life Insurance or Annuities (all life insurance applicants must complete)

1. INSURED: Do you have any other annuities or life insurance currently in force or applied for? ☐ Yes ☐ No **If marked Yes, must complete in full:**

- **All details below must be completed in full** and if Being Replaced* is checked Yes, all state specific replacement forms must be completed.

Use Section J if you have additional insurance coverage information to document.

- You must check Yes to Being Replaced* if there is **any** possibility that the new RiverSource Life Insurance Company (RiverSource Life) policy will replace another policy currently in force or applied for.
- In states that have adopted the NAIC Model Regulation for Insurance and Annuity Replacements, you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Company Name | Plan Type

Policy Number | Insurance Amount $ | ADB Amount $ | Being Replaced*? ☐Yes ☐ No

Company Name | Plan Type

Policy Number | Insurance Amount $ | ADB Amount $ | Being Replaced*? ☐Yes ☐ No

Internal Replacements: If Being Replaced* is checked Yes, and you are replacing a RiverSource Life policy:

- By signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: ☐ applied to the new RiverSource Life policy ☐ returned to the client

2. Second INSURED: Do you have any other annuities or life insurance currently in force or applied for? ☐ Yes ☐ No **If marked Yes, must complete in full:**

- **All details below must be completed in full** and if Being Replaced* is checked Yes, all state specific replacement forms must be completed.

Use Section J if you have additional insurance coverage information to document.

- You must check Yes to Being Replaced* if there is **any** possibility that the new RiverSource Life policy will replace another policy currently in force or applied for.
- In states that have adopted the NAIC Model Regulation for Insurance and Annuity Replacements, you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Company Name | Plan Type

Policy Number | Insurance Amount $ | ADB Amount $ | Being Replaced*? ☐Yes ☐No

Company Name | Plan Type

Policy Number | Insurance Amount $ | ADB Amount $ | Being Replaced*? ☐Yes ☐No

Internal Replacements: If Being Replaced* is checked Yes, and you are replacing a RiverSource Life policy:

- By signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: ☐ applied to the new RiverSource Life policy ☐ returned to the client

Section D — Disability Income and Business Expense Protection Insurance Plan Applied For Information

1. Disability Income Insurance Plan

Base Monthly Benefit

$

Insured's Occupation Class:

❑ 1A ❑ 2A ❑ 3A ❑ 3M
❑ 4A ❑ 4M ❑ 5A ❑ 5M

Waiting Period:

❑ 30 days ❑ 60 days ❑ 90 days
❑ 180 days ❑ 365 days

3. Submit Application Supplement Form 33507 (available on DI Illustration System)

Duration of Benefit: ☐ 1 year ☐ 3 years ☐ 5 years ☐ to age 65 ☐ to age 67

Premium Pattern: ☐ Level ☐ Step Rate

Disability Provision

8.

Occupation Classes 1A, 2A, 3A & 3M:	☐ Income Protection Plus with 2 year occupation protection (IPP-2)
Occupation Classes 4A, 4M, 5A & 5M:	☐ Income Protection Plus with 5 year occupation protection (IPP-5)
Occupation Classes 4A & 5A:	☐ Income Protection Plus (IPP)
Occupation Classes 4A, 5A & 5M:	☐ Income Protection with Residual Benefits (IPTr)
Occupation Classes 3A, 4A, 4M, 5A & 5M:	☐ Income Protection (IPMod)

Group Rate Options — Please indicate below ONLY if either of the following apply to this application:

☐ Employer Plan Coverage Unisex Rates ☐ Multiple Case Discount (see online reference materials for all qualification details)

2. Disability Income Insurance Riders

9.

☐ Social Benefits Rider $ per month with waiting period of days.

☐ Supplemental Income Rider $ per month and benefit paid up through month with day waiting period.

☐ Cost of Living Maximum (classes 2A, 3A, 3M, 4A, 4M, 5A and 5M)
Maximum: ☐ 3% ☐ 4% ☐ 5% ☐ 6% ☐ 7% ☐ 8% ☐ 9% ☐ 10%

☐ Future Purchase Option $ Pool Amount

☐ Other

3. Disability Income Insurance Premiums

Annual Premium $.

A. Bank Authorization (BA): ☐ Monthly ☐ Quarterly

3.

☐ New BA Authorization (Complete Form 200517) ☐ Add to Existing BA with Account Number

B. Direct Bill: ☐ Quarterly ☐ Semiannual ☐ Annual

C. Card Billing: ☐ American Express ☐ Master Card ☐ VISA

Frequency (not available for initial payment) ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Card Number Expires

D. Other:

4. Disability Underwriting Information

A. Complete description of job duties

Years of service Number of hours worked per week

Self-employed? ☐ Yes ☐ No 1. Date business began (MM/YYYY) Number of employees

2. What percent of duties are supervisory? %

B. Any contemplated change in occupation? ☐ Yes ☐ No If yes, explain

C. Previous occupation if changed in the past five years

D. Amount of unearned income $ Source

Section D — Disability Income and Business Expense Protection Insurance Plan Applied For Information

4. Disability Underwriting Information (continued)

E. Is the insured a member of a State, Public, or Federal Retirement System? ☐ Yes ☐ No

If yes, which one?

F. Is the Insured eligible for or does the Insured have any Disability Income Insurance through his/her employer?

a. Short-term: ☐ Yes ☐ No at $ per month for months and day waiting period

b. Long-term: ☐ Yes ☐ No at $ per month for months and day waiting period

c. If yes to b., is the group long-term disability integrated with Social Security? ☐ Yes ☐ No

G. Will the Insured's employer be paying the premiums for the RiverSource Life Disability Insurance? ☐ Yes ☐ No

H. Is the Insured eligible for benefits from a required state Cash Sickness disability program? ☐ Yes ☐ No

I. Existing Disability Insurance (all DI applicants must complete)

INSURED: Do you have any other disability insurance currently in force or applied for? ☐ Yes ☐ No

If yes, provide the information below, indicate **if this insurance is replacing** any of the existing policies, and submit state-specific replacement forms. Replacement must be indicated **even if it is not certain** that the new RiverSource Life policy will replace another company's policy currently in force or applied for. Use Section J if you have additional insurance coverage information to document.

Company Name | DI Yrs. Payable | Plan Type

Policy Number | Insurance Amount/Monthly Income $ | Being Replaced? ❑ Yes ❑ No

Company Name | DI Yrs. Payable | Plan Type

Policy Number | Insurance Amount/Monthly Income $ | Being Replaced? ❑ Yes ❑ No

5. Business Expense Protection Insurance Plan

(Cannot be applied for without personal Disability Income Protection in force or applied for with RiverSource Life or other Company.)

Complete Disability Underwriting Information Section

Monthly Benefit $

3. Submit DI Application Supplement Form 33507 (available on DI Illustration System)

Insured's Occupation Class: ☐ 3A ☐ 3M ☐ 4A ☐ 4M ☐ 5A ☐ 5M

Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days

Benefit Pattern: ☐ Level ☐ Increasing

☐ Multiple DI Case Discount (see online reference materials for all qualification details).

6. Business Expense Protection Insurance Premiums

Annual Premium $.

3. A. Bank Authorization (BA): ☐ Monthly ☐ Quarterly

☐ New BA Authorization (Complete Form 200517) ☐ Add to Existing BA with Account Number

B. Direct Bill: ☐ Quarterly ☐ Semiannual ☐ Annual

C. Card Billing: ☐ American Express ☐ Master Card ☐ VISA

Frequency (not available for initial payment) ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Card Number Expires

D. Other:

Section E — Medical History/Underwriting Information for the Insured

IT IS VERY IMPORTANT THAT YOUR ANSWERS ARE ACCURATE AND COMPLETE. OMMISSIONS OR MISSTATEMENTS COULD AFFECT YOUR INSURANCE COVERAGE.

Insured's Name

1. Doctor or Clinic Patient Number

Street Address City

State ZIP Code Phone Number 2. Height (Feet/Inches) Weight (Pounds)

3. Date Last Seen (MM/DD/YYYY) Reason Last Seen

4. Have you ever had, or been told you had, consulted with, been tested for, or treated by a doctor, medical practitioner or any other type of health care provider for the following? **(Respond Yes or No to every question and document additional details for Yes answers in Section J.)**

Problems with or Disorder of the:	Date of Last Consultation, Test or Treatment (MM/YYYY)	Problems with or Disorder of the:	Date of Last Consultation, Test or Treatment (MM/YYYY)
a) ☐ Y ☐ N Cancer or tumor		l) ☐ Y ☐ N Diabetes or high blood sugar	
b) ☐ Y ☐ N Unusual fatigue		m) ☐ Y ☐ N Epilepsy	
c) ☐ Y ☐ N Muscles		n) ☐ Y ☐ N Stroke or memory loss	
d) ☐ Y ☐ N Bones, neck, back, joints		o) ☐ Y ☐ N Loss of consciousness	
e) ☐ Y ☐ N Skin		p) ☐ Y ☐ N Paralysis	
f) ☐ Y ☐ N Liver or hepatitis		q) ☐ Y ☐ N Brain or nervous system	
g) ☐ Y ☐ N Kidneys or urinary tract		r) ☐ Y ☐ N Depression	
h) ☐ Y ☐ N Digestive or reproductive system		s) ☐ Y ☐ N Dysthymia	
i) ☐ Y ☐ N Heart, chest pain or circulation		t) ☐ Y ☐ N Stress or anxiety	
j) ☐ Y ☐ N High blood pressure		u) ☐ Y ☐ N Other emotional disorder	
k) ☐ Y ☐ N Lung or breathing		v) ☐ Y ☐ N Alcohol or drug/substance abuse	
		w) ☐ Y ☐ N Currently pregnant	

5. **Other than listed above**, within the past five years have/do you:

Date of Last Consultation, Test or Treatment (MM/YYYY)

a) ☐ Y ☐ N Stayed overnight in a hospital or gone to an emergency room for any illness or injury?
b) ☐ Y ☐ N Been to a medical clinic, therapist, doctor, or health care provider?
c) ☐ Y ☐ N Presently have a physical impairment or illness?

If Yes for a, b or c, give reason:

6. Have you ever been diagnosed or received treatment by a health care provider for AIDS (Aquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex) or have you ever had a positive HIV test? ☐ Yes ☐ No
Date of last consultation, test or treatment (MM/DD/YYYY)

7. Have you ever used marijuana, cocaine, heroin, or amphetamines? ☐ Yes ☐ No Date of last use (MM/YYYY)

8. a. Have you ever used tobacco or nicotine in any form? ☐ Yes ☐ No b. If yes, what is/was used?
c. What amount? Date last used? (MM/YYYY)

9. Do you have any current plans to travel outside of the United States? ☐ Yes ☐ No If yes, how long?
Where Reason When

10. During the past five years have you:
a. Flown, or do you contemplate flying, as a pilot, student pilot or crew member? ☐Yes ☐ No
b. Participated in or do you contemplate participating in motorcycle riding, racing (automobile, snowmobile, motorcycle, boat), skin/scuba diving, skydiving, hang gliding, or other similar activities? ☐Yes ☐ No If yes, what activity?
c. Had your driver's license revoked, received a moving violation or been cited for a DUI/DWI? ☐Yes ☐ No
If yes, what? When? (MM/DD/YYYY)

11. Have you ever had an application for insurance declined, postponed or modified in any way? ☐Yes ☐ No
If yes, provide date Company Name
Reason

Section F — Medical History/Underwriting Information for the Second Insured

IT IS VERY IMPORTANT THAT YOUR ANSWERS ARE ACCURATE AND COMPLETE. OMMISSIONS OR MISSTATEMENTS COULD AFFECT YOUR INSURANCE COVERAGE.

Second Insured's Name

1. Doctor or Clinic | Patient Number

Street Address | City

State | ZIP Code | Phone Number | 2. Height (Feet/Inches) | Weight (Pounds)

3. Date Last Seen (MM/DD/YYYY | Reason Last Seen

4. Have you ever had, or been told you had, consulted with, been tested for, or treated by a doctor, medical practitioner or any other type of health care provider for the following? (Respond Yes or No to every question and document additional details for Yes answers in Section J.)

Problems with or Disorder of the:	Date of Last Consultation, Test or Treatment (MM/YYYY)	Problems with or Disorder of the:	Date of Last Consultation, Test or Treatment (MM/YYYY)
a) ☐Y ☐N Cancer or tumor		l) ☐Y ☐N Diabetes or high blood sugar	
b) ☐Y ☐N Unusual fatigue		m) ☐Y ☐N Epilepsy	
c) ☐Y ☐N Muscles		n) ☐Y ☐N Stroke or memory loss	
d) ☐Y ☐N Bones, neck, back, joints		o) ☐Y ☐N Loss of consciousness	
e) ☐Y ☐N Skin		p) ☐Y ☐N Paralysis	
f) ☐Y ☐N Liver or hepatitis		q) ☐Y ☐N Brain or nervous system	
g) ☐Y ☐N Kidneys or urinary tract		r) ☐Y ☐N Depression	
h) ☐Y ☐N Digestive or reproductive system		s) ☐Y ☐N Dysthymia	
i) ☐Y ☐N Heart, chest pain or circulation		t) ☐Y ☐N Stress or anxiety	
j) ☐Y ☐N High blood pressure		u) ☐Y ☐N Other emotional disorder	
k) ☐Y ☐N Lung or breathing		v) ☐Y ☐N Alcohol or drug/substance abuse	
		w) ☐Y ☐N Currently pregnant	

5. Other than listed above, within the past five years have/do you:

Date of Last Consultation, Test or Treatment (MM/YYYY)

a) ☐Y ☐N Stayed overnight in a hospital or gone to an emergency room for any illness or injury?

b) ☐Y ☐N Been to a medical clinic, therapist, doctor, or health care provider?

c) ☐Y ☐N Presently have a physical impairment or illness?

If Yes for a, b or c, give reason:

6. Have you ever been diagnosed or received treatment by a health care provider for AIDS (Aquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex) or have you ever had a positive HIV test? ☐Yes ☐No

Date of last consultation, test or treatment (MM/DD/YYYY)

7. Have you ever used marijuana, cocaine, heroin, or amphetamines? ☐Yes ☐No Date of last use (MM/YYYY)

8. a. Have you ever used tobacco or nicotine in any form? ☐Yes ☐No b. If yes, what is/was used?

c. What amount? Date last used? (MM/YYYY)

9. Do you have any current plans to travel outside of the United States? ☐Yes ☐No If yes, how long?

Where Reason When

10. During the past five years have you:

a. Flown, or do you contemplate flying, as a pilot, student pilot or crew member? ☐Yes ☐No

b. Participated in or do you contemplate participating in motorcycle riding, racing (automobile, snowmobile, motorcycle, boat), skin/scuba diving, skydiving, hang-gliding, or other similar activities? ☐Yes ☐No If yes, what activity?

c. Had your driver's license revoked, received a moving violation or been cited for a DUI/DWI? ☐Yes ☐No

If yes, what? When? (MM/DD/YYYY)

11. Have you ever had an application for insurance declined, postponed or modified in any way? ☐Yes ☐No

If yes, provide date Company Name

Reason

Section G —Agreement to Sell, Transfer or Assign Life Insurance

"Any party to the application" is defined as the applicant, proposed insured, owner, if other than the applicant, or any beneficiary. "Third party" is defined as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity.

1. Agreements or Incentives - Has any party to the application:
   - Entered, or made plans to enter, into any agreement or contract to sell or assign the ownership of, or a beneficial interest in, the applied for policy; or
   - Been promised or agreed to by any person that they will be given, or have been given, any inducement, fee or compensation as an incentive to purchase the policy; or
   - Received, or will receive, from any person any inducement, fee or compensation as incentive to purchase the policy?

   ☐ No ☐ Yes

2. Prior Transactions - Has any party to the application ever:
   - Sold, transferred or assigned any life insurance policy to a third party; or
   - Received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?

   ☐ No ☐ Yes

For any "Yes" responses to 1 or 2 above, provide details regarding any agreements, incentives or prior transactions.

Section H — Juvenile Insurance COMPLETE IF INSURED IS UNDER AGE 15

Did the advisor see this child? ☐ Yes ☐ No

Is there similar insurance in force or applied for on all brothers and sisters? ☐ Yes ☐ No

If not, why?

Amount of life insurance already in force on the person responsible for child's primary support $

Signature of Parent or Legal Guardian X

Signature of Witness X

Date (MM/DD/YYYY)

Section I — Children's Insurance Rider Information

A. Name(s) of children to be covered by rider (must be under age 19 and unmarried)

Name (First, Full Middle, Last)	Birthdate (MM/DD/YYYY)	Sex	Physical/Mental Abnormalities at Birth? (If yes, explain below)
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

B. Has anyone listed above received treatment for any disease, physical or mental condition in the past five years? ☐ Yes ☐ No

C. Is this insurance intended to replace any existing insurance and/or annuity? ☐ Yes ☐ No

D. If Yes to B or C above, explain here

E. Are there any children under the age of 19 and unmarried not listed above? ☐ Yes ☐ No

If Yes, List Name Birthdate (MM/DD/YYYY)

Reason for Exclusion

Section J — Notes (Include details to any "Yes" answers for medical questions and additional replacement information. If one check submitted for multiple products, please specify dollar amount to each product.)

Section K -- Credit or Charge Card Billing

(Not available for initial premium payment. Available with Term and Disability Income insurance products only.

- By signing for card billing, you authorize RiverSource Life Insurance Company to bill your card account for the insurance premiums and frequency indicated in Sections B or D and you understand that payments will be automatically billed to your card account.
- You understand that RiverSource Life Insurance Company may receive updated card account information from your card company.
- You understand you may discontinue this payment at any time. The arrangement will remain in effect until you notify RiverSource Life Insurance Company in writing to cancel it, allowing reasonable time to act on your cancellation. Any such notification shall be effective only with respect to entries initiated after receipt of, and reasonable time to act upon such notification, usually 15 days.
- RiverSource Life Insurance Company reserves the right to terminate this agreement at any time upon 30 days written notification.

10. ## Section L — Arbitration (Applicable to applicants in the states of AZ, CO, DC, HI, ID, NV, RI only)

11. 1. The parties understand and agree that any disputes which arise in any way related to this policy shall be subject to binding arbitration. You understand and agree that:
   - Arbitration is final and binding on you and us;
   - You and we waive any right to seek remedies in court, including the right to jury trial, but any arbitration award may be enforced in court;
   - Pre-arbitration discovery is generally more limited than, and different from, court proceedings;
   - The arbitrators' award is not required to include findings or legal reasoning, and any party's right to appeal or to seek modification of rulings by the arbitrators is strictly limited; and
   - Arbitration will be governed by the Federal Arbitration Act and conducted in accord with the rules and procedures of the forum you choose from the following: American Arbitration Association (AAA), National Arbitration Forum (NAF) or JAMS/Endispute (JAMS). If you do not choose a forum within 60 days of notifying us of any dispute, we will have the right to choose a forum from among NAF, JAMS, or AAA.

2. Unless you object, we will pay all fees payable to the arbitrator(s). To the extent the matter in dispute is deemed to be an issue governed exclusively or primarily by the Financial Industry Regulatory Authority (FINRA), you will have the option to arbitrate the matter in accordance with the rules and procedures specified by the FINRA provided the FINRA will hear the matter.

3. In consideration of the issuance of this insurance policy or contract, there shall be no right or authority for any dispute to be (i) arbitrated on a class action basis or (ii) brought in a purported representative capacity on behalf of the general public, other contract holders of RiverSource Life or other persons similarly situated; provided, however, that any individual dispute you may have would be subject to this Arbitration Provision. Furthermore, disputes cannot be consolidated in the Arbitration with disputes brought by or against others. You also agree not to serve as a representative of any certified or putative class with respect to any dispute.

Section M — State Fraud Notices

For Applicants in Colorado only:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Applicants in Arkansas and Louisiana only:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

12. For Applicants in District of Columbia only:

WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Applicants in Maryland only:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Applicants in New Mexico only:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

For Applicants in Oklahoma only:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Applicants in Ohio only:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For applicants in Tennessee and Washington only:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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1. RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

1a. RiverSource Insurance

Life and Disability Income Insurance Application

Agreement and Signature

Agreement. By signing this application, you acknowledge all of the following terms and conditions.

Identification and Verification. We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to open your account. If we are unable to verify your identity, we reserve the right to close your account or take such other steps as we deem reasonable.

When coverage begins. You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and

The premium has not been returned by the company; and

The Insured has submitted all medical and other information required by the company's written underwriting rules; and

The Insured is insurable on the Effective Date, as defined below, under the company's underwriting rules, for the plan and amount of coverage at the rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of all medical examinations and other information (which may include the company's medical information gathering interview) required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid.

For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin. (This limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage. If coverage begins prior to delivery of the policy under the conditions described above, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of $500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy applied for.

Amount of Disability Insurance Coverage. If coverage begins prior to delivery of the policy under the conditions described above, the disability coverage monthly benefit on the Insured will be the lesser of (1) $3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy until the first of the following to occur: (1) benefits paid and payable total $500,000; or (2) the Insured is no longer eligible for benefits under the terms of the policy because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's responsibilities. You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest If required by law;

No change in or waiver of anything in this application or alteration of an insurance policy is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy. (Not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia.) However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Adequate Information. You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the attached RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Qualified Plans only. You certify that the plan under Ownership of the insurance application is qualified under Section 401(a) of the United States Internal Revenue Code. This policy will be issued based on representations by you that the Plan is qualified.

Life Protection/Universal Life Insurance/Variable Universal Life Insurance/Survivorship Variable Life Insurance. If you have applied for this type of insurance, you understand and acknowledge that (1) a projection of future death benefits and policy values will be provided upon written request; (2) surrender charges may apply in certain circumstances; (3) no-lapse guarantee or death benefit guarantee features as applicable to the type of insurance applied for have been adequately described to you and may involve premium in excess of your scheduled premium; and, (4) interest at rates in excess of the guaranteed interest rate will accrue on any policy value/fixed account value at rates determined by the company and at the company's discretion. These rates will be based on various factors including, but not limited to, the interest rate environment, returns earned on investments backing these policies, the rates currently in effect for new and existing company policies, product design, competition and the company's revenues and expenses.

Declaration. You declare that each of the answers made in this application is true and complete to the best of your knowledge and belief and will be a basis for any policy issued. You also acknowledge that you have received a copy of this agreement and receipt for any premium paid with this application.

Authorization and Certification. By your signature below, the owner authorizes the Medical Information Bureau, employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid the original, and that this authorization will be valid for 30 months from the date shown below.

13.

Social Security or Taxpayer Identification Number (TIN) Certification as required by Form W-9 of the Internal Revenue Service (IRS)

Under penalties of perjury, you certify that:

1. The number shown on this form is your correct taxpayer identification number, and
2. You are not subject to backup withholding because: (a) you are exempt from backup withholding, or (b) you have not been notified by the IRS that you are subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified you that you are no longer subject to backup withholding, and
3. You are a U.S. citizen or other U.S. person (defined below).

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Form W-9 instructions are available upon request or on irs.gov.

Certification Instructions — You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The IRS does not require your consent to any provision of this document other than certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print) | Signed on Date (MM/DD/YYYY) | State

Insured's Signature (base plan) X

Second Insured's Signature X

Owner's Signature (other than Insured) X

Parent/Legal Guardian's Signature (for Insureds under age 15) X

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from | the sum of $ | . | with this application.

Advisor's Report

14.

Is Insured related to advisor? ☐ Yes ☐ No If yes, give relationship

You certify that you personally requested the information in this application and witnessed its signing and received any money that was paid. You also certify that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Team ID | Advisor's Signature X | Advisor Number

Comp % | Area Office Number | Phone Number | Ext.

Advisor's Name | Fax Number

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? ❑ Yes ❑ No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above. Advisor

Number | Name

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Team ID | Advisor's Signature X | Advisor Number

Comp % | Area Office Number | Phone Number | Ext.

1. RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

1a. RiverSource Insurance

Life and Disability Income Insurance Application

Agreement and Signature

Agreement. By signing this application, you acknowledge all of the following terms and conditions.

Identification and Verification. We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to open your account. If we are unable to verify your identity, we reserve the right to close your account or take such other steps as we deem reasonable.

When coverage begins. You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and

The premium has not been returned by the company; and

The Insured has submitted all medical and other information required by the company's written underwriting rules; and

The Insured is insurable on the Effective Date, as defined below, under the company's underwriting rules, for the plan and amount of coverage at the rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of all medical examinations and other information (which may include the company's medical information gathering interview) required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid.

For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin. (This limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage. If coverage begins prior to delivery of the policy under the conditions described above, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of $500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy applied for.

Amount of Disability Insurance Coverage. If coverage begins prior to delivery of the policy under the conditions described above, the disability coverage monthly benefit on the Insured will be the lesser of (1) $3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy until the first of the following to occur: (1) benefits paid and payable total $500,000; or (2) the Insured is no longer eligible for benefits under the terms of the policy because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's responsibilities. You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest If required by law;

No change in or waiver of anything in this application or alteration of an insurance policy is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy. (Not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia.) However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Adequate Information. You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the attached RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Qualified Plans only. You certify that the plan under Ownership of the insurance application is qualified under Section 401(a) of the United States Internal Revenue Code. This policy will be issued based on representations by you that the Plan is qualified.

Life Protection/Universal Life Insurance/Variable Universal Life Insurance/Survivorship Variable Life Insurance. If you have applied for this type of insurance, you understand and acknowledge that (1) a projection of future death benefits and policy values will be provided upon written request; (2) surrender charges may apply in certain circumstances; (3) no-lapse guarantee or death benefit guarantee features as applicable to the type of insurance applied for have been adequately described to you and may involve premium in excess of your scheduled premium; and, (4) interest at rates in excess of the guaranteed interest rate will accrue on any policy value/fixed account value at rates determined by the company and at the company's discretion. These rates will be based on various factors including, but not limited to, the interest rate environment, returns earned on investments backing these policies, the rates currently in effect for new and existing company policies, product design, competition and the company's revenues and expenses.

Declaration. You declare that each of the answers made in this application is true and complete to the best of your knowledge and belief and will be a basis for any policy issued. You also acknowledge that you have received a copy of this agreement and receipt for any premium paid with this application.

Corporate Office Copy

Authorization and Certification. By your signature below, the owner authorizes the Medical Information Bureau, employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid the original, and that this authorization will be valid for 30 months from the date shown below.

13.

Social Security or Taxpayer Identification Number (TIN) Certification as required by Form W-9 of the Internal Revenue Service (IRS)

Under penalties of perjury), you certify that:

1. The number shown on this form is your correct taxpayer identification number, and
2. You are not subject to backup withholding because: (a) you are exempt from backup withholding, or (b) you have not been notified by the IRS that you are subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified you that you are no longer subject to backup withholding, and
3. You are a U.S. citizen or other U.S. person (defined below).

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Form W-9 instructions are available upon request or on irs.gov.

Certification Instructions — You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The IRS does not require your consent to any provision of this document other than certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print) | Signed on Date (MM/DD/YYYY) | State

Insured's Signature (base plan) X

Second Insured's Signature X

Owner's Signature (other than Insured) X

Parent/Legal Guardian's Signature (for Insureds under age 15) X

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from _____ the sum of $ _____ . _____ with this application.

Advisor's Report

14.

Is Insured related to advisor? Yes No If yes, give relationship

You certify that you personally requested the information in this application and witnessed its signing and received any money that was paid. You also certify that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Team ID | Advisor's Signature X | Advisor Number

Comp % | Area Office Number | Phone Number | Ext.

Advisor's Name | Fax Number

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? ❑ Yes ❑ No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above. Advisor

Number | Name

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Team ID | Advisor's Signature X | Advisor Number

Comp % | Area Office Number | Phone Number | Ext.

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
Company Tracking Number:	*134803AR*		
TOI:	*L06I Individual Life - Variable*	*Sub-TOI:*	*L06I.002 Single Life - Flexible Premium*
Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEMN-125688858*	*State:*	*Arkansas*
Filing Company:	*RiverSource Life Insurance Company*	*State Tracking Number:*	*39689*
Company Tracking Number:	*134803AR*		
TOI:	*L06I Individual Life - Variable*	*Sub-TOI:*	*L06I.002 Single Life - Flexible Premium*
Product Name:	*Life Insurance*		
Project Name/Number:	*Life/DI 2008 Application/134803*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 06/09/2008

Comments:

Attachments:

AR CH 19 CERT 134803.pdf
AR GTY NOTICE.pdf
ARNOTIC2.pdf
Readability Certification.pdf

Review Status:

Satisfied -Name: Statement of Variability 07/15/2008

Comments:

Attachment:

Statement of Variability 134803.pdf

STATE OF ARKANSAS

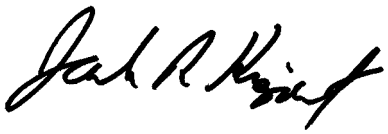
Life and Disability Income Application

CERTIFICATION OF COMPLIANCE

Forms: **134803** **Life and Disability Income Application Form**

We certify that the above form being submitted meet the provisions of Rules 19 of the Arkansas Insurance Department Rules and Regulations as well as all applicable requirements of the Department.

I, Jack R. Kispert, Assistant Secretary of RiverSource Life Insurance Company, further certify that I am familiar with the applicable laws, rules and regulations of the State of Arkansas, and that to the best of my knowledge, information and belief, all forms submitted with this letter are in compliance in all respects with the provisions of the Insurance Laws, Rules and Regulations of the State of Arkansas.



RiverSource Life Insurance Company
Jack R. Kispert, Assistant Secretary

Date: July 21, 2008

Limitations and Exclusions under the Arkansas Life and Disability Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state, and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

RiverSource Life Insurance Company
70100 Ameriprise Financial Center
Minneapolis, MN 55474

John Doe
XXXX-XXXXXXXX

Questions Regarding Your Policy?

If you have questions regarding your policy, you may contact the following:

RiverSource Life Insurance Company
Policyowner Service Department

70100 Ameriprise Financial Center
Minneapolis, MN 55474

Tele: 1-800-862-7919 **(Hours are 7 am - 8 pm Central Standard time)**

Representative Name: John Smith

Representative Address: Ameriprise Financial Services
1234 Main Street
Little Rock, AR 72204

If we at RiverSource Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904

Tele: 1-800-852-5494

RiverSource Life Insurance Company
848 Ameriprise Financial Center
Minneapolis, MN 55474

CERTIFICATION OF READABILITY

RiverSource Life Insurance Company certifies, to the best of its knowledge and belief, that the below listed policy forms meet the minimum reading ease score as set forth in your state's Policy Language Simplification Act. These forms are at least 10 (ten) point type, 2 (two) point leaded.

Title	Form Number	Flesch Score
Life and Disability Income Application	134803	40.0

Signature:_____

Jack R. Kispert
Assistant Secretary

Date: July 21, 2008

RiverSource Life Insurance Company
Statement of Variability

Application Form 134803

Brackets have been placed around various items in the form in order to indicate that they are variable and subject to change by us as explained below.

- Formatting may change due to future changes in typestyle and/or electronic generation of the forms. However, any adaptation we make will not involve changes to text without any necessary prior approval and will always meet or exceed the requirements of your state.
- We reserve the right to correct typographical errors.

1. Corporate address: If our street address or telephone number changes.

1a. Logo: bracketed to allow for future logo changes.

2. Instructions: Bracketed for future instruction clarification needs to assist both advisors and applicants in completing the application.
3. Service form names or numbers referenced throughout: If the form number or name changes for any referenced service form.
4. The version letter/print date will be changed if any future changes are made to items bracketed as variable.
5. Section B 1: Permanent Insurance product section: These are bracketed in case the product names are changed, if additional products are available or discontinued in the future. Any new products would be filed with your department, if required, for prior approval.
6. Part B 2: Life Insurance Riders. These are bracketed in the event the product or rider names are changed, increase percentage option changes, if riders are not offered for new issues of the contract or if additional products are available or discontinued in the future. Any new products or riders would be filed with your department, if required, for prior approval.
7. Part B 4: Consent for Delivery of Initial Prospectuses on CD-ROM: This is bracketed for three reasons: 1) The Company decides to no longer offer this service, this provision will be removed; 2) bracketed also in the event that this language is removed and placed into a separate acknowledgement form for applicants to sign; and 3) bracketed to allow for text change within this provision to clarify or add additional language relating to consenting to receiving a CD ROM.
8. Section D: Bracketed in case the Occupation Classes need to be revised and/or in case the product names are changed, if additional products are available or discontinued in the future. Any new products would be filed with your department, if required, for prior approval.
9. Section D 2: Disability income Insurance Riders. These are bracketed in the event the product or rider names are changed, increase percentage option changes, if riders are not offered for new issues of the contract or if additional products are available or discontinued in the future. Any new products or riders would be filed with your department, if required, for prior approval.
10. Section L: States are bracketed for possible changes to the list of states to which requires the Arbitration language.
11. Section L: Arbitration language is bracketed for possible changes from FINRA.
12. Section M: State Fraud notices are bracketed in case additional state fraud warnings are added or if existing fraud notices are no longer required or are revised.
13. TIN Certification: For possible changes to Federal TIN certification required language.
14. Advisor's Report: This section is attached to the application for convenience to the agent and is not subject to review and approval. The information may change as needed to identify the selling agent, pay compensation, verify replacement of coverage, add notes from the agent, etc.